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ABSTRACT

This report presents data on Asian and Pacific Islander Americans (APIAs), focusing on California. It discusses: who APIAs are; nativity and citizenship; residence (nearly all APIAs reside in metropolitan areas, particularly California); educational attainment (because of the model minority myth about Asians, APIA children are deprived of bilingual classes and bicultural counselors); language ability (APIAs have no common language); economic status (the combination of relatively high median income and high poverty reflects the great economic diversity of APIAs); APIA politics (political empowerment is a significant challenge); health (as a group, Asians are healthier than others, but they face disparate health risks); access to health care (many APIAs are uninsured); children's health coverage; cultural and linguistic competency standards for the Healthy Families Program; barriers to care (cost, insurance, and linguistic and cultural differences); health service utilization (APIAs underutilize mental health, preventive, and prenatal services); traditional medicine; health professions and health providers; public benefits (immigrants are considerably less likely than natives to receive welfare); pressing health and social issues; culturally competent health and social services; and race relations. (Contains 31 references.) (SM)

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ED 467 357

OVERVIEW OF ASIAN AND PACIFIC ISLANDERS IN THE UNITED STATES AND CALIFORNIA

A Series of Community Voices Publications

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Who are Asian and Pacific Islander Americans?

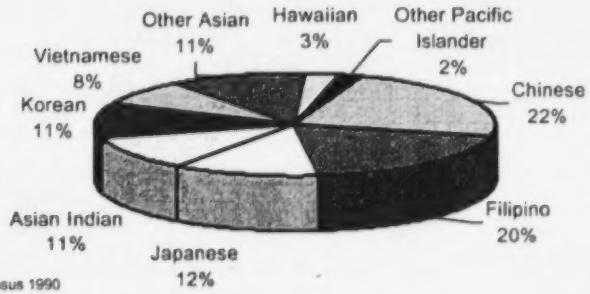
Asian and Pacific Islander Americans (APIAs) are one of the fastest growing populations in the U.S. In 1999, the APIA population was estimated at 11 million representing 4 percent of the total population. In comparison, Hispanics represent 11% and African Americans 12% of the total population.

By 2020, the APIA population is estimated to have almost doubled (20 million). Immigration and high fertility rates are the primary factors in the fast growth of the APIA population and the Hispanic population.

Asian Pacific Islander Americans refers to a diverse and heterogeneous group of people whose roots span from China to Papua New Guinea to Pakistan to Hawaii.

An APIA is a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent. Pacific Islanders include persons from Polynesian, Micronesian, and Melanesian ancestries. Not surprisingly, given the vast geographical range of Asia and the Pacific Islands, APIAs differ in language, religion, health practices and beliefs, and other characteristics.

U.S. Asian and Pacific Islander Population, 1990
total population = 7,226,986



Source: U.S. Census 1990

California Asian and Pacific Islanders, 1990
Total population = 2,746,754

Source: U.S. Census 1990

U.S. Population, 1999
(in thousands)

Total	273,866	100%
White	196,409	72%
Black	33,278	12%
Hispanic	31,767	11%
Native American	2,033	1%
APIA	10,379	4%

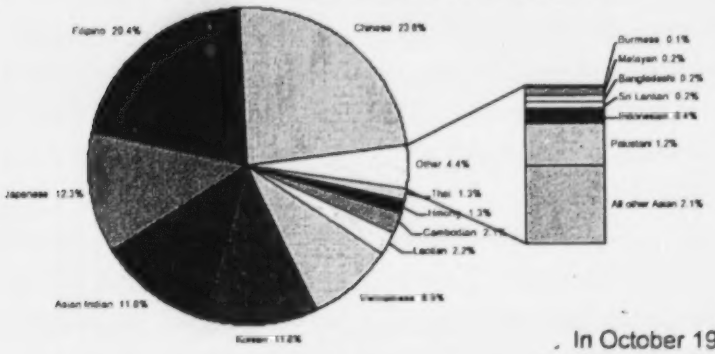
Source: U.S. Census Bureau, 1999

APIAs – National & Ethnic Origins

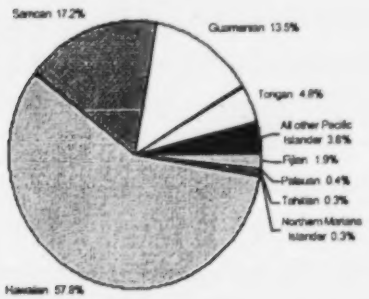
Bangladeshi
Bikini Islander
Burmese
Bhutanese
Borneon
Cambodian
Carolinian
Celebesian
Cerem
Cernam
Chinese
Eniwetok Islander
Fijian
Filipino
Guamanian
Hawaiian
Hmong
Indian
Indochinese
Indonesian
Iwo-Jiman
Japanese
Javanese
Korean
Kwajalein Islander
Laotian
Malayan
Maldavian
Mariana Islander
Marshallese
Marshall Islander
Melanesian
Micronesian
Mongolian
Nepali
New Hebrides Islander
Okinawan
Pakistani
Palauan
Papua New Guinean
Polynesian
Ponapean
Saipanese
Samoan
Sikkim
Singaporean
Solomon Islander
Sri Lankan
Tahitian
Tarawa Islander
Thai
Tibetan
Tinian Islander
Tokelauan
Tongan
Trukese
Vietnamese
Yapese

Due to small numbers, the historical category of "Other Asian" included Native Hawaiians, Pacific Islanders, and smaller Asian ethnic subgroups in the U.S.

Percent Distribution of the Asian Population, 1990



Percent Distribution of the Pacific Islander Population, 1990



In October 1997, OMB Directive 15 disaggregated the "Asian or Pacific Islander" category into separate categories of "Asian" and "Native Hawaiian or Other Pacific Islander".

By creating separate categories, the data on Native Hawaiians and other Pacific Islander groups will no longer be overwhelmed by the aggregate date of the much larger Asian groups.

Nativity and Citizenship

Immigration has been a major factor in the growth of the APIA population, with large numbers coming to the US after the adoption of the Immigration Act of 1965.

In 1997, 61% of APIAs were foreign-born, compared to 38% of Hispanics, 8% of Whites, 6% of African Americans and 6% of Native Americans.

The percent of those foreign born varies by ethnicity. For example, in the 1990 Census over 60% of Japanese Americans reported being native born compared to 20% of Vietnamese Americans.

Top Ten Countries of Origin for Legal Immigrants. 1998	
Mexico	131,575
China	36,884
India	36,482
Philippines	343,466
Dominican Republic	20,387
Vietnam	17,469
Cuba	17,375
Jamaica	15,146
El Salvador	14,590
Korea	14,268

Immigrants have the option of becoming naturalized citizens or remaining "permanent resident aliens". Asians generally naturalize to a great extent and faster than immigrants coming from other parts of the world (Barringer et al, 1993). The proportion of those who become naturalized is, of course, dependent upon a number of factors including sponsorship and duration of residency. Of all 1970-1979 APIA immigrants, over 55% had become citizens by 1988 (USINS 1998 yearbook).

Citizenship and legal status often determines the availability of federal and state health and social services.

The anti-immigrant campaigns in California and in Congress in the last five years have been partly responsible for inspiring the greatest rush to naturalization in the history of the United States. (Mydans, 1995)

Residence

The majority of APIAs reside in the West. In 1990, 54% of Asians, 86% of Pacific Islander lived in the West compared to 21% of the total population. APIAs now make up 12% of California's population and 63% of Hawaii's population.

Nearly all APIAs (94%) reside in metropolitan areas.

Top 5 states, 1997	APIA population
California	3.8 million
New York	952,736
Hawaii	748,748
Texas	523,972
New Jersey	423,838

Top 5 counties, 1997	APIA population
Los Angeles County, CA	1.2 million
Honolulu County, HI	559,752
Orange County, CA	334,330
Santa Clara County, CA	343,387
Queens County, NY	317,893

Nearly one-third of all immigrants reside in California. Los Angeles (18.2%) and the San Francisco Bay area (5.3%) account for almost a quarter of the country's immigrants.

APIA households (Pacific Islanders – 4.1 person per household, Asians – 3.8 persons per household) are larger than the nation's average household (3.2 persons per household).

Within metropolitan areas, APIA households were 8 times more likely than White households to be crowded (24 % compared to 3%). Crowded is defined as households with more than one person per room.

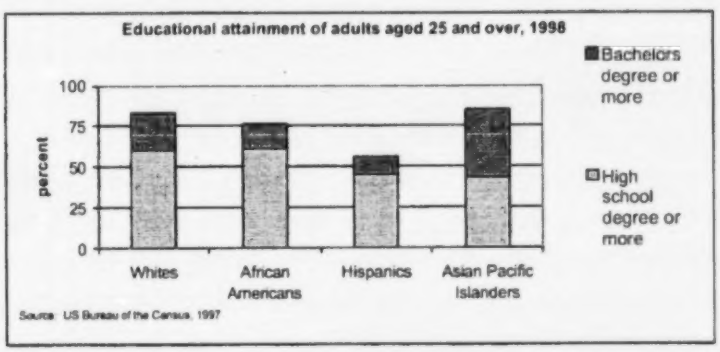
As other immigrant populations have done, many first generation Asian ethnic groups established segregated communities. Early Chinese immigrants established "Chinatowns" in San Francisco, Los Angeles, and other cities. Koreans, Vietnamese, and other Indochinese immigrants and refugees established their own ethnic enclaves. In contrast, Filipinos and Asian Indian immigrants are widely scattered.

These ethnic enclaves provide a foothold for immigrants as they learn a new language and transition into a new life. With each succeeding generation, APIA and Hispanic immigrants tend to move into more mainstream integrated neighborhoods. From a health and welfare perspective, ethnic enclaves provide immigrants with the linguistic and cultural social support that might otherwise be difficult to find.

Asian Health Services (AHS) located in Oakland's Chinatown is a comprehensive primary care community health clinic that provides services for primarily low-income and uninsured APIAs. Interpretation services are offered in nine different languages: English, Cantonese, Mandarin, Korean, Vietnamese, Tagalog, Cambodian, Laotian and Mien. By focusing on community, AHS is able to provide linguistically appropriate and culturally competent services to Oakland's diverse APIA population.

Educational attainment

In 1998, the vast majority (85%) of APIAs 25 years and older had obtained at least a high school diploma and 42% of APIAs had earned at least a bachelor's degree compared to 83% and 24% of the total population respectively.



Although education is highly valued among all Asian communities, the educational attainment of different Asian ethnicities varies widely. For example, in 1990 the proportion of Japanese completing high school was 88% compared to 31% of Hmong.

Because of the "model minority" myth – that Asians are perceived to excel in education – immigrant children, particularly Southeast Asian refugees, are deprived of educational services such as bilingual classes and bicultural counselors.

Language ability

APIAs speak over 100 languages and dialects. Unlike Hispanics who share the common languages of Spanish and Portuguese, there is no common language that binds APIAs. Even among ethnic groups, such as the Chinese, there is no common verbal language. For instance, while the Chinese share a common written language, those who speak Cantonese cannot verbally understand those who speak Mandarin and vice versa.

Nearly 66% of APIAs speak an Asian or Pacific Islander language at home. Approximately 35% of APIAs are linguistically isolated (Census 1990). In terms of limited English proficiency, Pacific Islanders are the least limited and the Southeast Asians are the most limited.

English Ability of Children, by Generation, 1990

Speaks only English at home	1st Generation	2nd Generation	3rd Generation
APIA children	10.7 %	49.6 %	85.3 %
Hispanic children	2.9 %	16.0 %	65.7%

Source: 1990 Census PUMS

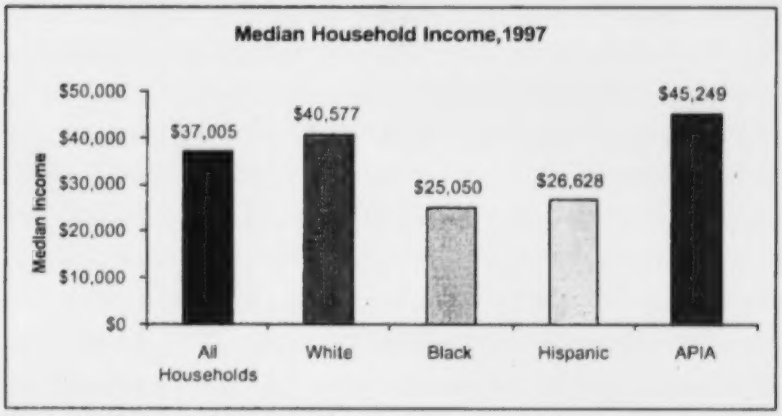
There is a serious lack of translation services for APIAs in health and social services settings. When translation services are available, they are generally very limited by language and dialect. Linguistically appropriate health and social services are necessary to assure that minority populations have equal access to care.

> There are no funds in the hospital budget specifically earmarked for interpreters there have often been no Hmong-speaking employees of any kind present in the hospital at night. Obstetricians have had to obtain consent for cesarean sections or episiotomies using embarrassed teenaged sons, who have learned English in school, as translators. Ten-year-old girls have had to translate discussions of whether or not a dying family member should be resuscitated. Sometimes not even a child is available. (Fadiman, 1997)

According to the Asian & Pacific Islander American Health Forum (1997), only seven federally funded community health centers exist to provide linguistically and culturally appropriate primary health care to APIAs. Only two residential recovery programs exist in the U.S. to treat APIA substance abusers (both are in California: San Francisco and Los Angeles).

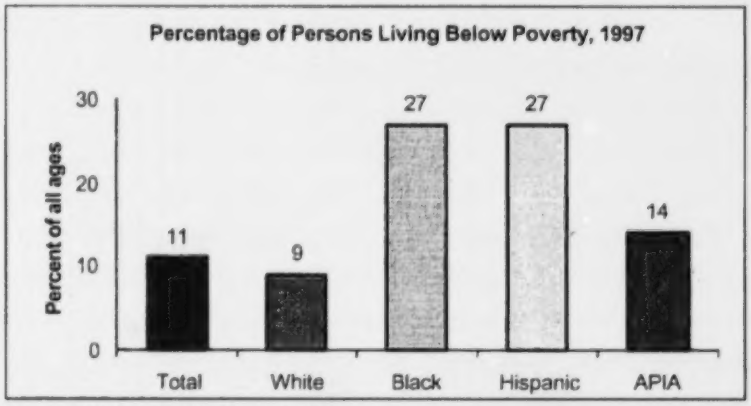
Economic status

The combination of relatively high median income and high poverty reflects the great economic diversity of the APIA community.



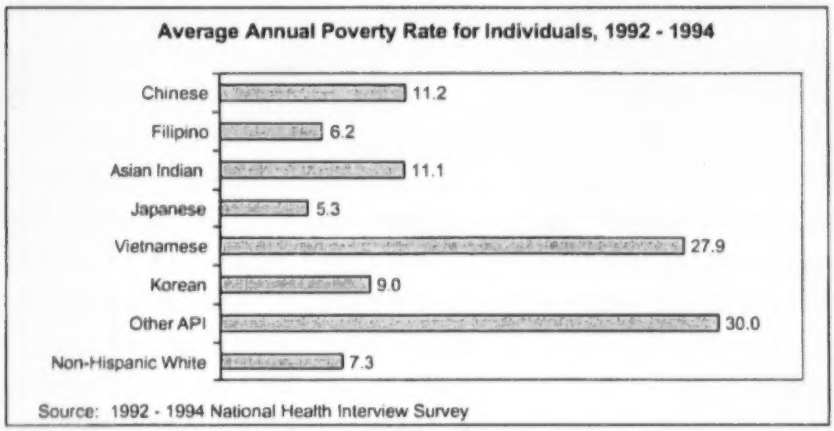
Source: U.S. Bureau of the Census, 1998

APIA families ($44,460) and non-Hispanic White ($41,110) families have comparable median incomes (US Bureau of the Census, 1993). However, there are great differences in income among Asian ethnic subgroups. For example, according to the 1990 Census, the median family income of Japanese Americans exceeded that of non-Hispanic white families, whereas the income of Cambodian American families was lower than that of African American families.



Source: U.S. Bureau of the Census, 1998

Despite higher educational attainments and comparable median family incomes, the poverty rate for APIAs (12.5%) was higher than that for non-Hispanic Whites (8.2%). The rate of poverty varies widely among APIA ethnicities. In 1990, more than 60% of Hmong Americans and 40% of Cambodian Americans were living below the poverty line compared to 7% of Japanese Americans or 6% of Filipino Americans.



In California, Southeast Asians represented the highest percentage of persons below the poverty level by ethnicity among APIA ethnic groups: Hmong (63%), Laotian (51%), and Cambodian (47%).

In order to make a living, many immigrants take underpaid jobs with poor working conditions.

The Garment Industry (Bonacich, 1994)
Immigrants and women are among the cheapest and most exploitable of workers. Asian immigrant women are an important component of the U.S. garment labor force, along with other immigrant workers from Mexico and the Caribbean area. Wages and working conditions are notoriously bad. Most workers are paid on a piecemeal basis. Inexperienced workers have a hard time coming up to minimum wage. Benefits or paid vacation time are almost nonexistent. The 1990 estimates of the number of garment workers in Los Angeles is between 95,900 to 120,000.

Silicon Valley's Electronic Piecework Industry (Mercury News, 1999)
Some high tech industries are using networks of immigrant workers to assemble printed circuit boards and cables piece-by-piece for as little as a penny per component. Similar to the garment industry, many workers earn less than minimum wage, are not paid overtime, and face retaliation for seeking recourse from government labor officials. Additionally, many immigrant workers expose their families to hazardous materials by doing the work at home.

A 1996 Rand study showed that "Japanese, Korean, and Chinese immigrants enter with wages much lower than those of native-born workers, but that their earnings increase rapidly. Within 10-15 years, their wages reach parity with those of native-born workers. Mexicans, on the other hand, enter with very low wages and experience a persistent wage gap."

Small business

Employees of small business often are left uninsured.

"Small business owners often want to provide insurance at a low cost to employees and they want to have a choice in plans, but very often these businesses don't have the ability to offer insurance in a cost efficient way." -- Rosa Gil, DSW, special advisor to the mayor for health policy and director of Health Services in New York City.

The rise in health care costs has made it difficult for small businesses to begin or continue to offer insurance coverage for their employees.

APIA-owned small business

In part, due to the high percentage of foreign-born APIAs, there is an over-representation of APIAs in the small business sector.

Bruce Cain and Roderick Kiewiet, in their 1986 study of minority-owned businesses in California, found that the businesses are primarily sole proprietorships, using family and other unpaid employees, and profits are generally small. APIAs have an advantage by having greater family resources resulting in larger capital and employee bases than other minority groups. However, they are more likely to be hampered by language problems and dependence upon ethnic clientele.

Out of 3.25 million minority-owned businesses, there were 1.1 million Asian-owned businesses, compared to 1.4 million Hispanic-owned businesses and 880,000 African American-owned businesses.

Although Asian-owned businesses represented just one-third of all minority-owned businesses, they accounted for a majority ($275 billion or 56%) of the $495 billion total minority-owned businesses generated in 1997 followed by Hispanic-owned businesses ($184 billion or 37%) and African American-owned businesses ($59 billion or 12%).

Asians are the most likely to have employees: nearly one-quarter of Asian-owned businesses in 1997 had employees, versus one-seventh of Hispanic-owned businesses and one-tenth of African American-owned businesses. Asian-owned firms employed more than 1.9 million workers in 1997.

About 75% of Asian business owners were between the ages of 25 and 54. Just under one-third were born in the U.S. (32%).

Immigrants pay more in taxes than they use in services over their lifetimes. The direct taxes paid by immigrants are roughly $133 billion in 1997. If the taxes paid by immigrant businesses are included, the total would be at least $162 billion. (Moore, 1998)

Immigrants in small business

Recent immigrants are more likely to be employed in small firms than earlier immigrants who are more likely to be employed in small firms than native-born persons.

Even among persons with the same amount of skill, recent immigrants are more likely to be employed in small firms than earlier immigrants and the native born.

Even after many years in the U.S., immigrants are more likely to be employed in small firms than native-born persons.

The likelihood of being employed in a small firm is directly related to an immigrant's ability to speak English and is therefore dependent on their country of origin. Those who immigrate from non-English speaking countries are more likely to be employed in small firms than those from English-speaking countries.

Overall, the number of Asian-owned businesses has skyrocketed by 180% from 1987 to 1997, to a total of 1.06 million businesses, nationally. Estimated revenue from these businesses in $275 billion, a 463% increase since 1987.

Asian Pacific Islander American politics

Political empowerment remains to be one of the largest challenges that APIAs face.

Despite APIA history that dates back to the 1800s, as Helen Zia writes: "Asian Americans have lost at least three generations of political development because of federal laws that barred us from citizenship and full political participation. It was not until 1952 that all Asian Americans got the right to become citizens and to vote, when Congress finally struck down the last of the anti-Asian exclusionary citizenship laws."

In 1999, there were 3 Asian American members of Congress from Hawaii and only five others in the House that includes the Pacific Islander non-voting representatives from Guam and American Samoa.

In California, APIAs now account for one-third of the members on the San Francisco Board of Supervisors.

In Santa Clara County, more than 60% of the 106,000 APIA voters registered in the last six years.

Governor Gary Locke (WA) is the first and only mainland APIA governor.

There is increasing involvement of APIAs in electoral politics. By 1998, more than 300 APIAs were elected to office in the U.S. and its territories.

Republicans once dominated among Asian Americans, but now registrations are evenly divided among both parties and those voters who decline to state their affiliation.

Health

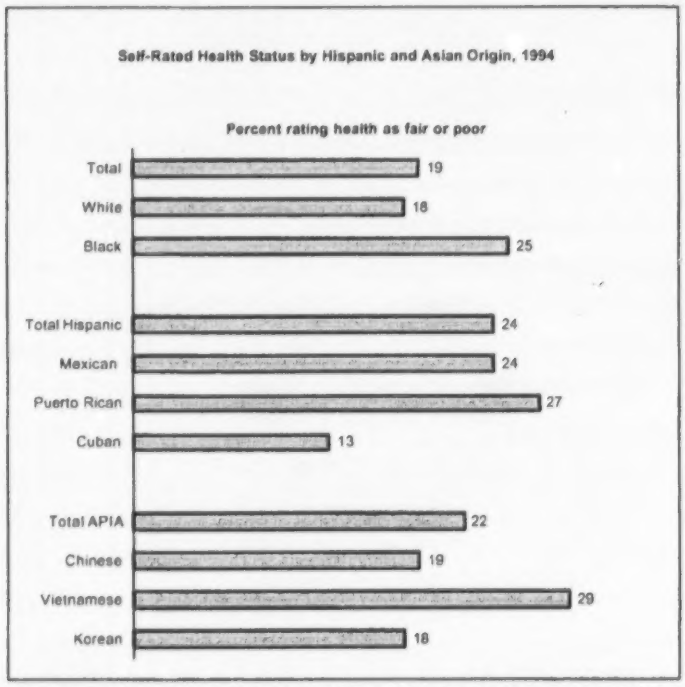
General health measures indicate that overall Asians, as a group, are healthier than Whites and other minorities. However, a closer examination reveals disparate health risks faced by Asians and Asian ethnic groups.

Life Expectancy, 1992.

Whites	75.1
Asian	80.3
Chinese	81.7
Japanese	82.1
Native Hawaiian	68.3
Filipino	80.6
Vietnamese	78.8
Korean	82.3

Source: CDC/NCHS

Although national data reveal that age-adjusted death rates for Asians (285.8 per 100,000) were lower than Whites (477.5 per 100,000) (Monthly Vital Statistics Report, 1995), life expectancy data reveal that there are differences in life expectancy across Asian ethnic groups. In particular, Native Hawaiians fare more poorly than Whites and other Asian ethnic groups.



More APIAs (22%) and Hispanics (24%) rated their health as fair or poor than Whites (18%).

Wide variation exists among Asian ethnic groups. Vietnamese Americans reported fair or poor health more often than either Chinese or Korean Americans.

Source: The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care

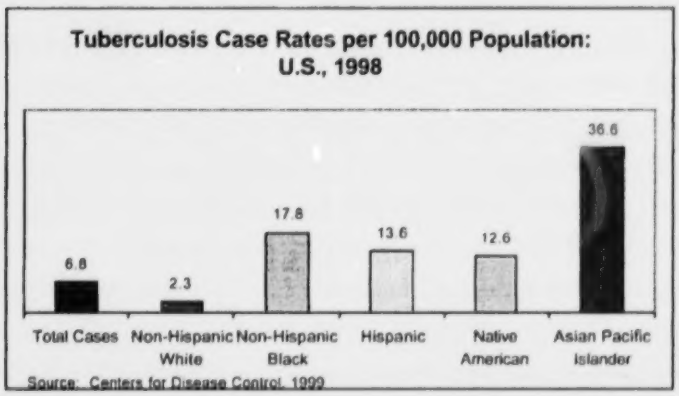
Although, general health statistics appear to be favorable for Asians, a closer examination reveals several areas where Asians fare worse than Whites. For instance, data from the Surveillance, Epidemiology and End Result program (SEER) reveal that several Asian ethnic groups experience excess incidence of stomach cancer and liver cancer compared to Whites.

Cancer Incidence Rates per 100,000 Population, 1988-1992.

Site	White	Chinese	Filipino	Japanese	Korean	Vietnamese
Stomach	6.4	11.8	6.9	22.0	30.5	26.0
Liver	2.2	12.6	6.7	5	16.3	23.9

Source: NIH/NCI, SEER

Two infectious diseases that disproportionately affect APIAs are tuberculosis and hepatitis.



Incidence Rates for Tuberculosis, California 1990.

Total	11.5
White	4.2
Black	30.8
Native American	23.1
Hispanic	26.2
Asian Pacific Islander	53.3

Source: Dumbauld, 1994

Summarizing the findings from community-based studies, Tong (1994) and Hann (1994) showed that the prevalence rates of hepatitis B in Asian ethnic subgroups range from 5% to 15% compared to 0.2% for the general population.

Oral disease remains pervasive among millions of children in the U.S. Children from low-income families and racial and ethnic minorities (including APIAs) are at high risk of oral disease.

There continues to be a lack of data regarding the health and well being of many of the smaller APIA groups. Empirical data suggests that certain APIA groups, such as Southeast Asians fare much worse than predominant Asian groups (e.g., Chinese, Japanese and Filipino) with regards to mortality and specific health issues (e.g., tuberculosis, depression, etc...). Based on the empirical data, it is clear that using the aggregate measure of "Asian" does not accurately reflect the health risks or health status of the smaller Asian and Pacific Islander groups.

Access to Health Care

An individual's ability to access quality health care is largely dependent upon whether he or she has health insurance. For immigrants and racial/ethnic minorities, the challenge of accessing health care is compounded by the lack of insurance coverage for traditional or culturally based medicine (e.g., acupuncture and herbal medicine) and other non-financial barriers ranging from transportation to the lack of culturally competent providers.

Many APIAs are uninsured because they work in small businesses or services industries that do not offer health insurance.

Uninsured persons in 1998

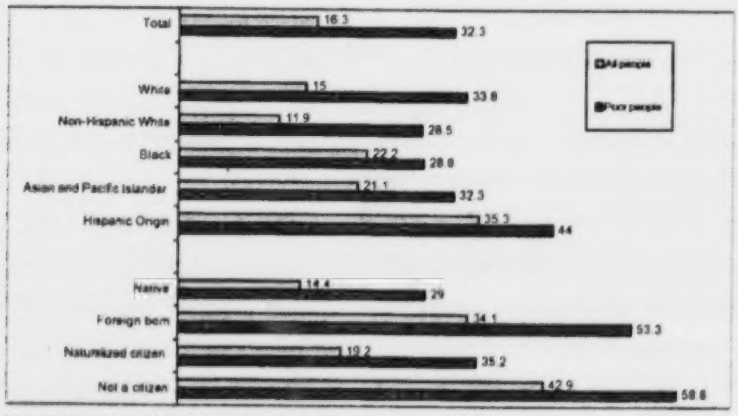
	Percent uninsured	Number uninsured
United States	16.3 %	44.3 million
California	22.1 %	7.2 million

Source: U.S. Census Bureau, 1999

The uninsured rate in 1998 among all APIAs was higher than that of non-Hispanic Whites – 21.1 percent compared to 11.9 percent. Among poor people, the uninsured rate among APIAs (32.3 percent) was higher than non-Hispanic Whites (28.5 percent) and Blacks (28.8 percent).

The foreign-born population was more likely to be without health insurance than natives—34.1 percent compared with 14.4 percent in 1998. Poor immigrants were even worse off—53.3 percent were without health insurance.

People Without Health Insurance for the Entire Year: 1998



Source: U.S Census Bureau, Current Population Survey, March 1999

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Health Insurance Coverage, APIAs, Ages 0-64, 1997

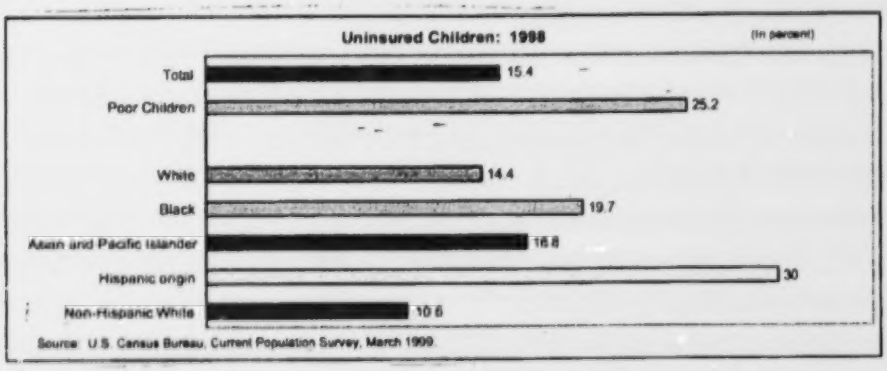
	Uninsured	Job-based insurance	Medicaid	Privately purchased insurance	Other government coverage
APIAs overall	21%	64%	7%	6%	2%
South Asians	22%	69%	4%	5%	0%
Chinese	20%	67%	2%	10%	1%
Filipinos	20%	73%	2%	3%	2%
Japanese	13%	77%	2%	7%	1%
Koreans	34%	48%	1%	14%	3%
Southeast Asians	27%	49%	18%	4%	2%
Other APIAs	23%	59%	11%	5%	2%

Source: March 1998 Current Population Survey

Children's health care coverage

The total number of uninsured children was 11.1 million (15.4 percent) in 1998. Among poor children, 3.4 million (25.2 percent) were uninsured. Poor children made up 30.6 percent of all uninsured children.

APIA children were more likely than non-Hispanic Whites to be uninsured, though less likely to be uninsured compared to other minority groups.



Uninsured population, 1994-95

	California		United States
	Number (thousands)	Percent Uninsured	Percent Uninsured
Total (nonelderly)	5,560	19.7	15.5
Children under age 19	1,185	12.5	10.4
Adults (19-64)	4,375	23.3	17.9

Source: Kaiser Family Foundation, 1999

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The two primary publicly funded programs that provide children with health insurance are Medicaid and the State Children's Health Insurance Program (S-CHIP). Medicaid covers about 3 out of ten children (27 million in 1997). Children under 6 living below 133 percent of the poverty line are eligible for Medicaid. By 2002, children under 19 living below the poverty line ($13,880 for a family of three in 1999) will become eligible. States do have the flexibility to expand the eligibility limits.

S-CHIP was created in 1997 to cover children from families who did not qualify for Medicaid, but who could not afford private coverage. Twenty-nine states (including California) and D.C. provide coverage for children at or above 200 percent of poverty ($27,760 for a family of three in 1999). Healthy Families (California's S-CHIP) covers children, ages 19 or below, up to 250% of poverty. States also have the flexibility to expand the eligibility limits of these programs.

Cultural and Linguistic Competency Standards for Healthy Families Program - 11/15/99

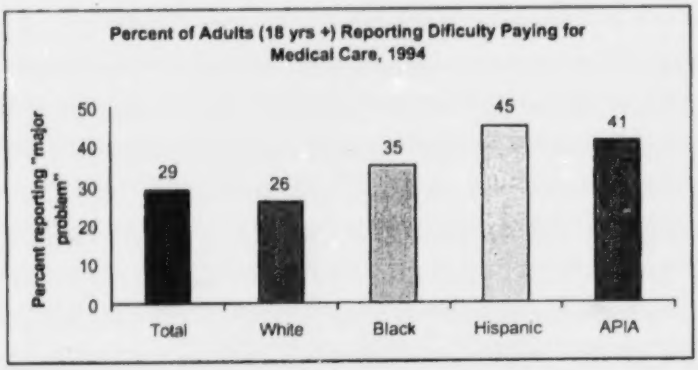
The Managed Risk Medical Insurance Board (MRMIB) is currently considering the cultural and linguistic competency standards for the Healthy Families Program (HFP). The proposal being looked at by MRMIB is being criticized by healthcare access advocates as inadequate in meeting the cultural competency service needs of those eligible for HFP.

The HFP is the state's program to provide health insurance for uninsured, low-income children below 19 years old. There has been mounting concern that the program's enrollment efforts be able to reach immigrant communities; otherwise, eligible children will remain uncovered and without access to care. Likewise, it is imperative that service providers on contract with HFP be held to cultural and linguistic competency standards that ensure fullest access to services.

Asian Health Services has joined other advocates through the California Pan-Ethnic Health Network in calling on MRMIB to fully adopt the existing DHS Medi-Cal managed care cultural and linguistic service requirements. Furthermore, advocates are also calling on MRMIB to convene a cultural and linguistics standards task force or work group to monitor implementation of the requirements and to further develop the standards.

Barriers to Care

APIAs face barriers to care similar to those of the general population, such as high medical costs and lack of health insurance. In addition, APIAs may face additional barriers to care, such as language difficulties and lack of cultural understanding and sensitivity by providers.



Source: The Commonwealth Fund 1994 National Comparative Survey of Minority Health

There is a general lack of knowledge about the specific knowledge, attitudes, beliefs, and values of particular APIA ethnic subgroups and how these may affect health care practices and disease interventions.

The lack of quantitative and qualitative data on the health and the health care practices of APIAs, demonstrates the need for targeted research so that culturally competent care can be provided and that effective interventions (i.e. preventive health education) can be designed.

Furthermore, given the increasing evidence that social support and emotional well being, it is necessary for providers to understand the socio-cultural environment of the patient.

Non-citizen residency status, particularly undocumented residency status, deters many from seeking eligibility for entitlement and other publicly sponsored programs. Complex eligibility processes and service arrangements deter immigrants from accessing care.

> "Most old people prefer not to go to the doctor. They feel, maybe doctor just want to study me, not help my problems. They scary this. If they go one time, if they not follow appointment and do like doctor want, doctor get mad. Doctor is like earth and sky. He think, you are refugee, you know nothing."
>
> (from interviews of Hmong in Merced, CA – Fadiman, 1997)

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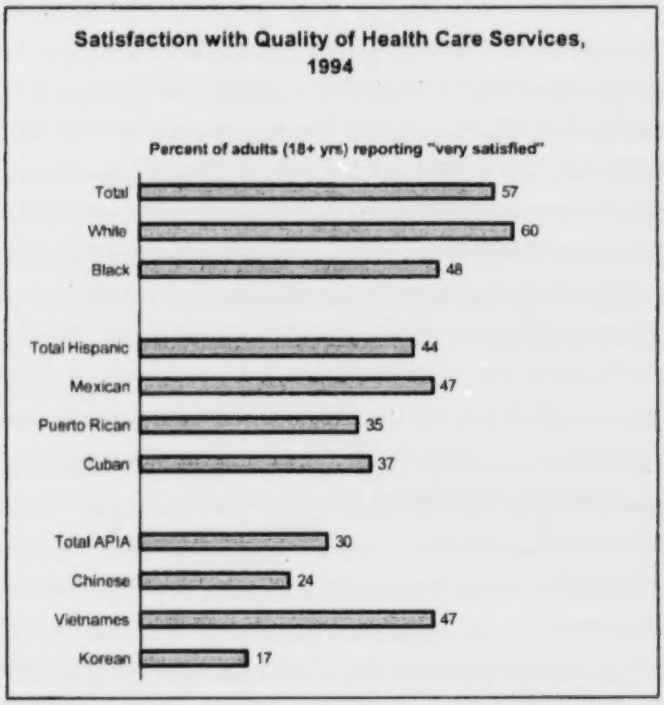
Utilization of Health Services

There is increasing evidence that Apia's use fewer health services than Whites and other minority groups even after adjusting for health status. This includes under-utilization[1] of mental health services, preventive care and prenatal use.



Source: The Commonwealth Fund 1994 National Comparative Survey of Minority Health Care.

Minority adults are less likely than white adults to feel "very satisfied" with the care they receive.

Less than one-third of APIAs and less than one-half of Blacks and Hispanics feel very satisfied with their care.

Chinese and Korean Americans reported the lowest levels of satisfaction with their health care services.

Cultural attitudes and beliefs may hinder the use of mental health services in APIA families.

Compared with Whites and other ethnic groups, Apia's underutilize mental health services (Sue 1994). As a result, when Apia's seek treatment, cases are often more severe and require more intensive services.

The underutilization may, in part, be due to different conceptions of mental health and disturbance by Apia's and mainstream Americans. Because of the strong stigma and shame that is attached to mental illness, Apia's may not acknowledge mental illness or disorder and avoid seeking help.

Certain groups of APIA women are less likely to use preventive care and prenatal care than White women.

[1] The term 'under-utilization' is specifically used to imply that Asians are not using services even though the need for care exists.

In "The Commonwealth Fund 1998 Survey of Women's Health", less than half of the APIA women respondents received physical exams, cholesterol tests, breast exams and pap smears in the preceding year – the lowest of all racial and ethnic groups in the survey. Almost one-third of APIA women reported receiving no preventive services at all.

In one California County, 40% of Korean women reported never having a pap smear compared to 8% of all women living in the county (Public Health Service, 1997).

Numerous barriers exist that prevent APIA communities from accessing the oral health care they need.

Financing dental services remains one of the most significant barriers to accessing necessary oral care. Lack of dental insurance, particularly for employees of small businesses and for the working poor, is a major barrier to obtaining services. In addition, APIAs are faced with the lack of linguistically appropriate and culturally competent oral health services.

Traditional medicine

APIA patients may first seek alternative, indigenous healers as the first line of health care or as parallel services.

For instance, in South Asian communities both ayurvedic (traditional Hindu system of medicine which is based on customs, beliefs, and practices of the Hindu culture. Ayurveda means "the science of life": veda – science, ayur – life.) and homeopathic medicine are well known and used. In East Asian communities, use of acupuncture and traditional herbal remedies are common. Often, alternative medicine is used in conjunction with Western medicine.

There is little to no data on the extent to which traditional medicine is used by itself or in conjunction with Western medicine.

Health Professions and Health Providers

When grouped as a whole, it appears that there is more than an adequate number of Asian physicians to serve the APIA population. Based on a physician to population ratio, the ratio of APIA physicians to APIA population is 887 per 100,000 compared to ratios of 251 per 100,000 for Whites, 128 per 100,000 for Hispanics, 72 per 100,000 for Blacks, and 50 per 100,000 for Native Americans.

Despite the high ratio of APIA professionals per population, a closer examination reveals that there is a lack of racial/ethnically similar physicians for several APIA communities such as Hawaiians and Laotians.

Physician to Population Ratio by Race/Ethnicity, 1990

Race/Ethnicity	# of Physicians	Population (# of Persons)	Ratio of Physicians to Population (per 100, 000)
Laotian	24	149,014	16
Cambodian	34	147,411	23
Samoan	21	62,964	34
Guamanian (Chamorro)	18	49,345	37
Hawaiian	134	211,014	63
Vietnamese	1,417	314,547	231
Japanese	3,772	847,562	445
Korean	5,797	798,849	726
Chinese	12,538	1,645,472	762
Other API	3,820	433,992	880
Filipino	13,250	1,406,770	942
Thai	996	91,275	1,092
Asian Indian	22,715	815,447	2,786
Total APIA	64,535	7,273,662	887
Non-Hispanic White	472,351	188,128,296	251
African American	21,538	29,986,060	72
Native American	979	1,959,234	50
Hispanic	27,023	21,113,528	128
Total	586,715	248,709,873	236

Source: U.S. Bureau of the Census, 1990

It appears that APIAs are "over-represented" in allopathic medicine and dentistry, however, due to the broad categorization of Asians as a whole, the distribution of students from Asian and Pacific Islander subgroups is unknown. Given the lower rates of educational attainment for groups such as Southeast Asians and Pacific Islanders, it seems likely that they would be "under-represented" in the health professions.

Total Enrollment in Schools for Selected Health Professions for Academic Years 1996-7

		Number of students	Percent of Students
Allopathic medicine	Non-Hispanic White	44,283	65.8
	Non-Hispanic Black	5,400	8.0
	Hispanic	4,424	6.6
	Native American	528	0.8
	Asian	11,808	17.6
Dentistry	Non-Hispanic White	11,100	67.7
	Non-Hispanic Black	891	5.4
	Hispanic	654	4.0
	Native American	83	0.5
	Asian	3,672	22.4
Nursing (RN programs)	Non-Hispanic White	193,061	81.0
	Non-Hispanic Black	23,611	9.9
	Hispanic	9,227	3.9
	Native American	1,816	0.8
	Asian	10,529	4.4

Source: Bureau of Health Professions

Immigrants and Public Benefits

What Federal Public Benefits can "Qualified" Immigrants Receive? (National Immigration Forum, Feb 1999)

"Qualified" Immigrants entering the U.S. on or after 8/22/96	**"Qualified" Immigrants in the U.S. before 8/22/96 (date of enactment of welfare law)**
Barred from Supplemental Security Income and Food Stamps. Subject to a 5-year bar on non-emergency Medicaid, the state Child Health Insurance Program, and Temporary Assistance for Needy Families. After 5-year bar, subject to deeming for the above programs. Exemptions from deeming up to one year exist for some battered spouses and children, and those at risk of going hungry or becoming homeless. After 5-year bar, states still retain the option to determine immigrant eligibility for TANF, Medicaid and social services block grants (Title XX).	Eligible for SSI: - if they were receiving the benefit on 8/22/96; or - if they are or become disabled. Eligible for Food Stamps: - if they were 65 years of age or older as of 8/22/96; - if they are under 18 years of age; - if they are disabled; - if they are a tribal member or family member of a Hmong or Highland Laotian tribe; OR - if they are a member of specific Indian tribes living along the U.S. border. States have the option to determine immigrant eligibility for TANF, Medicaid, and social services block grant (Title XX).

Note: "Qualified" immigrants include Lawful Permanent Residents; refugees and asylees; persons paroled into the country for at least one year; persons granted withholding of deportation; Cuban-Haitian entrants; Amerasians; and certain battered women and children.

"Deeming" is a process where the income and resources of the U.S. citizen or legal permanent resident sponsoring the immigrant are added to the immigrant's own income to determine whether the immigrant is poor enough to qualify for the benefit under the program's financial guidelines.

As a result of the new federal welfare law (the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), states acquired the authority to determine immigrants' eligibility for public benefits. While states gained the authority to bar noncitizens from public benefit programs such as TANF and Medicaid, states could also create new state-funded substitute benefits for immigrants.

According to a recent poll, 77% of Americans believe legal immigrants "should be eligible for the same kinds of public assistance that are available to the native-born."

Source: W.K. Kellogg Foundation poll by Bonney & Company. "The National Poll on Welfare Reform and Healthcare Reform," January 1999.

What is left is a patchwork of benefits available to immigrants that varies by state. The combination of the federal restrictions and the state choices resulting from PRWORA have led to increased fiscal inequalities across states. State and localities often carry a net fiscal burden, despite the fact that the federal tax contributions made by immigrants outweigh the cost of providing them with federally funded services. States with large immigrant populations, such as California and New York, are disproportionately burdened.

Except for refugees and elderly immigrants, immigrants are considerably less likely than natives to receive welfare. Among longer-term immigrants (at least ten years in the U.S.) of working age 3.2 percent are on welfare versus 3.7 percent for working-age natives. (Fix and Passel, 1994)

The California Experience

Despite the state's anti-immigrant reputation (brought on by the passage of Prop 187 and former Gov. Wilson's executive orders that restrict public benefits to undocumented immigrants), a recent study by The Urban Institute found that California is one of the most generous states in providing comprehensive state-funded benefits to qualified immigrants. Yet, it is also the most aggressive in trying to bar the unqualified from state public benefits.

Foreign-Born and Noncitizen Populations: 1996

	Foreign-born	Noncitizens	Noncitizens in Poverty	Noncitizens as a percentage of state poverty population
U.S. Total	24,937 (100%)	16,983 (100%)	4,697 (28%)	12.5
California	8,127 (33%)	6,048 (36%)	1,876 (31%)	31.0

Source: The Urban Institute

The politics are unique in California. There are increasing numbers of immigrants who are naturalizing to vote and immigrant advocacy groups that are growing in strength, yet public ballot initiatives disfavor immigrants. Despite the passage of ballot initiatives limiting immigrant benefits, the state legislature and other policymakers are clearly responding to California's large and increasingly powerful immigrant community and advocacy network.

Positive or Negative? California's benefit policies for immigrants

California ...	California ...
- is one of two states (the other being Maine) that provides state-funded substitute benefits in 4 key areas: food stamps, SSI, TANF, and Medicaid. - provides a substitute SSI program, however, it provides lower benefits to immigrants than to citizens. - makes state-funded SSI program available to post-enactment immigrants, though only if they have a sponsor who is abusive, disabled or deceased. - provides immigrants equivalent Medicaid services that were provided prior to PRWORA. - imposes a short sponsor-deeming period on post-enactment elderly and disable immigrants than is required under federal programs.	- at least 20 CA state agencies have issued regulations barring unqualified immigrants from various federal and state benefits and state-issued professional licenses, ranging from assistance on lead hazard control to the issuance of commercial driver's licenses. (Implementation of these regulations is still on hold due to court challenges.) - issued regulations barring unqualified immigrants from services provided under the Community Services Block Grant. - successfully passed ballot initiatives limiting affirmative action and bilingual education

What are the most pressing health and social issues facing Asian and Pacific Islander Americans?

Public charge

Recent immigration and welfare reform laws have generated considerable public confusion and concern about whether a non-citizen who is eligible to receive certain Federal, State, or local public benefits may face adverse immigration consequences as a "public charge" for having received public benefits.

Public charge, as defined in the Immigration and Naturalization Act, is when an individual is "primarily dependent on the government for subsistence."

By law, a non-citizen who is likely at any time to become a public charge is inadmissible and ineligible to become a legal permanent resident of the United States. Also, a non-citizen can be deported if he or she becomes a public charge within five years of entering the United States from causes that existed before entry.

In 1997, the issue of public charge became so confusing that immigrants avoided seeking basic health care and other needed services that were eligible to them because of fear that it would lead to denial of a green card or immigrant visa. For example, immigrant parents were afraid to enroll immigrant or citizen children in the new state Children's Health Insurance Program (CHIP) enacted in 1997 to protect the health of children in working families.

On May 25, 1999, the Administration clarified the new standard of public charge. The guidance provided that the only government programs that can have a negative effect on immigration status are cash welfare for income maintenance and long-term institutional care at government expense. It also clarified the circumstances under which receipt of cash welfare or institutionalization can become a factor in immigration determinations.

Availability of basic health and social services is limited due to "deeming".

"Deeming" is a process where the income and resources of the U.S. citizen or legal permanent resident sponsoring the immigrant are added to the immigrant's own income to determine whether the immigrant is poor enough to qualify for the benefit under the program's financial guidelines. Deeming will make most immigrants sponsored under the new affidavit of support ineligible for means-tested public benefits.

The use of public benefits by potential sponsors must be clarified.

A question on the Affidavit of Support (Form I-864) that asks whether the sponsor or a member of the sponsor's household has received means-tested public benefits within the past three years leads potential sponsors to incorrectly believe that if they use benefits they will be considered a public charge or found ineligible to be a sponsor.

There is a need to educate immigrants, health and social practitioners, immigration officers, and other professionals about public charge.

Because there has been so much confusion around the issue of public charge, many eligible immigrants are still fearful of using needed and available services. Likewise, health and social practitioners are unaware of the clarification and may be illegally prohibiting immigrants from receiving services.

Culturally competent health and social services

"More and more providers are treating a diverse group of patients, and culturally competent care improves health outcomes and patient satisfaction." --Guadalupe Pacheco, special assistant to the director of the Office of Minority Heath.

It is clear that providing culturally competent services will benefit the individual, the provider and the community. "Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross cultural situations. Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups. Competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities."

In other words, a culturally competent system of care would be one that does the following: 1) value diversity; 2) have the capacity for cultural self-assessment; 3) be conscious of the dynamics inherent when cultures interact; 4) have institutionalized cultural knowledge; and 5) have developed adaptations to diversity. Further, each of these five elements must function at every level of the system. Attitudes, policies, and practices must be congruent within all levels of the system. Practice must be based on

accurate perceptions of behaviors, policies must be impartial, and attitudes should be unbiased. (Cross, Bazron, Dennis, & Isaacs, 1989, p.v)

Various models, standards, and tools have been developed for providing culturally competent care. It should be noted that many of these models and tools must still be evaluated and refined. There have also been various policies that support the development and implementation of culturally competent care. Yet as with all policies, the accountability and programmatic and financial support has to be in place for the policies to be effective.

Race relations

Sa-i-gu, pronounced "sah-ee-goo", or April 2-9, became the most visible and devastating indication of the racial divide that APIAs experience. On April 29, 1992, Koreatown went up in smoke. By the end of the three-day uprising, more than 54 people had died and 4,500 shops were reduced to ashes. This particular event was the result of the growing tension between Korean Americans and African Americans and a need to unleash fury about social, economic and racial inequities that never got meaningfully addressed. Meanwhile, White Americans stood by watching.

Sa-i-gu highlighted the need to address inter- and intra- group relations. Stereotypes and misunderstandings are prevalent. For APIAs specifically, there remains the need to explain and share cultural beliefs, values, and practices with other groups. Likewise, APIAs must reach out to others and learn about their beliefs, values, and practices. There is a need to further develop pan-Asian organizations, so that race issues can be addressed on the community, as well as individual, level.

Intermarriage

Intermarriage is an example of how on an individual level Americans cross the racial and ethnic divide. It is the most potent example of America's melting pot.

"Both foreign born Asians and foreign-born Hispanics have higher rates of intermarriage than do U.S. –born Whites and Blacks. By the third generation, intermarriage rates for Asians and Latinos are extremely high. Fully one-third of third-generation Hispanic women are married to non-Hispanics, and 41% of third-generation Asian American women have non-Asian spouses." (National Immigration Forum, 1999)

From a community and economic development standpoint, improving race relations is not only important, but also necessary if racial and ethnic minorities are to maximize their potential and capture the opportunities afforded to them. Together, racial minorities can challenge the "glass ceiling" and can confront discriminatory policies and practices.

Like others, the hope of Asian and Pacific Islander Americans is to fully participate in the American dream.

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